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ABSTRACT

A coping process model is offered as a guide to the construction of intervention and planning programs for the mentally retarded. Current conceptions and measurement of adaptive behavior focus on whether or not a person handled a problem well, not how the person handles the problem situation. The paper views coping behavior as the process of adaptation, and adaptation as the end result of the coping process. A model for this coping process is described and includes a sequence of coping behaviors: confronting the situation, thoughtfully engaging the situation to find possible solutions, persistence at trying out solutions, and usually achieving solutions. Limitations of this application of the coping process are explored. Examples of training studies pertaining to independent functioning and personal and social responsibility are critiqued according to the coping process model. It is demonstrated that a fully conceptualized and operationalized intervention program for the mentally retarded could be based on this coping process model. (Author/SBH)

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The Relationship of Coping to Adaptive Behavior:
Implications for Education*

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The words Adaptation and Coping often occur together in the study of adaptive behavior and of coping behavior (Heber, 1961, Leland et al., 1967; Leland, 1978, Murphy, 1962, Coelho, 1974). Really, what is the difference between these two concepts?

The fusion of these concepts began with Heber's (1961) original definition of adaptive behavior as the "effectiveness with which an individual copes with the natural and social demands of his environment." When it came to measuring adaptive behavior, Nihira and Shellhaas (1970) described the activities in Parts I and II of the Adaptive Behavior Scale as coping behavior. In fact, they saw the ABS as a way of looking for important theoretical and empirical behavioral dimensions that would differentiate mentally retarded people according to their coping behavior. Both the definition and ABS measure of adaptive behavior conceptualize coping behavior as consisting of two major facets: independent functioning, and the degree to which a mentally retarded person meets the culturally imposed demands of personal and social responsibility (Heber, 1961; Foster and Nihira, 1974).

During the same time period that the study of adaptive behavior in the mentally retarded has been seeking definition and measurement,

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the same process has been occurring in the study of coping behavior. Coping behavior is often a general term (Murphy & Moriarty, 1976) that is composed of a constellation of acts (Lazarus, 1980). One point of agreement by several researchers is that coping is a process (Haan, 1977; Lazarus, 1980; Peck, 1967, 1979). Lois Murphy (1962) states that coping behavior is the process of adaptation, and adaptation is the end-result of coping. Zietlin (1980) defines coping as "an active, adaptive process of using strategies to manage one's world." Many researchers discuss coping as an intra-psychic process, however, Peck (1979) specifies a sequence of behaviors a person goes through in successfully dealing with a problem.

Some obvious comparisons exist between these two fields of study. Conceptually, these two fields of study are looking at some of the same behaviors that a person uses to handle themselves and the environment. Leland (1978) agrees that coping is a process of adaptation. He states that coping can be learned. Coping is probably that part of adaptive behavior which is the "reversible aspect of mental retardation (Leland, 1978). However, in practice, the measurement of adaptive behavior has focused on the end-result of the coping process. Both the Adaptive Behavior Scale and the Adaptive Behavior Inventory for Children (plus other AB measures) count the behaviors that a mentally retarded person demonstrates. However, these are static descriptions of what that individual was observed to do. These measures are a tally count of "can Joe do X" and they say nothing about "how" Joe went about learning or doing X behavior. On the other hand, the study of coping behavior looks at how a person goes about handling a problem. Effective coping behavior leads to an end-result of adaptation to the situation.

This relationship between coping and adaptation reminds me of a dream a friend of mine had. She was standing on a narrow ledge of the Grand Canyon when a part of her psychic-self fell off. The part of her that did not fall looked down and yelled "flap, dammit, flap." To everyone's amazement, a little arm flapping brought her back together again on the ledge. Well, one would have to give her a check-mark for having adapted to the situation. Upon closer examination, one could see that she confronted the problem, rather than ignoring her falling self; she engaged the problem: flapping does wonders; she didn't have time to try a lot of solutions, but fortunately persistence at flapping paid off; and in the happy ending, a solution was achieved. This dream is a good example of someone coping to achieve an adaptive behavior result.

Once the conceptual point is made that coping is the process of adaptation, of what value is that point to the study of adaptive behavior? Coulter and Morrow (1978a) state that measures of adaptive behavior have two purposes: identification/placement and intervention/programming. So far, a great deal of work has been done on creating reliable and valid measures of adaptive behavior for the purpose of identification/placement of mentally retarded people. Leland and Hussein (1973) go further to say that "technology for training adaptive behavior is integral to this theory (AB) because mentally retarded citizens must acquire skills that will support a minimum level of independent functioning required for normalization to be successful." However, after a study of a wide array of adaptive behavior measures (Coulter and Morrow, 1978b), it is not clear how intervention programs

can be generated from these measures. Adaptive behavior measures establish that a person does exhibit a specific behavior, but they do not show how the process of adaptation occurred. AB measures can be useful as pre and post measures in an educational intervention program (King, Soucar and Isett, 1980). Also, AB measures can suggest what specific areas of behavior are mal-adaptive and need intervention programming.

A possible answer as to what to put into an intervention program comes from the study of coping behavior. If coping is the process of adaptation, and maladaptive behavior is occurring, what aspects of the coping process are not being used? Since all of the components of the coping process are not completely known, any answer to this question is incomplete. However, the answer to this question can be sought by using a model of the coping process developed by Peck (1979). His model refers to behaviors that can be observed by anyone concerned with the care of mentally retarded people.

Peck and his associates developed a model of sequential steps in the coping process, and applied it cross-nationally to large samples of youth (Peck, 1979, 1980). It postulated that effective behavior was composed of three essential elements: Coping skills for dealing with problems, motivation to apply these skills, and feelings and attitudes that foster or impede thought and effort. These components were conceived as follows:

Coping skills. Coping is defined as a process of resolving problems. This sequence of steps applies to any sample of behavior in real life in which a person is confronted with a problem.

(1) Initially, one must assess whether the person mentally confronts the problem or not. Whenever the person thinks and talks about the issue, or expresses an intent to deal with it, this indicates a confronting stance, whereas, a purely emotional reaction which leads to verbal or physical aggression, with no attempt to deal with the substantive issue, is considered non-confronting.

(2) If the person does confront the issue, the next step is, does he/she try to do something about it; does the person engage in coping action? Attempting to resolve the problem is usually more effective than avoidance. If action occurs, the parallel question is, who initiated the action: the person him/herself, someone else, or he/she and another person, jointly? Sometimes, when a problem arises, advice, either solicited or unsolicited, is offered to the person. Better copers are those who tackle problems on their own, without needless calling for assistance, or having it recurrently thrust upon them as if people who knew them did not expect them to cope well on their own. Next, in the coping sequence, one must determine who originates the specific idea that is selected to solve the problem? Again, is the solution conceived by a person him/herself, by someone else, or through a joint effort? Other things being equal, self-solving of problems is hypothesized to indicate the better copers. Once a trial solution has been decided, who implements the action: the person, someone else, or both? As with the solver dimension, the order of effectiveness runs from "self," to "joint," to "other" implementation.

(3) In attempting to solve the problem, one must consider how much the person persists in trying to reach a solution. On the whole, better copers are those who would try alternative solutions if the first or second attempt did not work. When a first effort fails, or when an obstacle is encountered, non-copers simply give up, blame someone else, or sometimes explode in angry frustration.

(4) The final test of effective coping, though not the only one, is the achieving of a solution. In everyday life, some problems simply cannot be solved. Nonetheless, in looking at a variety of problems, good copers most often do succeed in working out at least a somewhat satisfactory resolution.

In summary, this model of the coping process indicates that adaptive behavior is obtained by following a process of confronting the problem, seeking solutions, persisting in finding a solution, and usually achieving a reasonable solution. This model can be applied to a wide array of behavior situations, including task achievement (self care and academic tasks). The components of this process were developed in an international study of children (Peck and associates, 1979, 1980), and these components have been measured by semi-projective and objective instruments. Using multiple regression analysis, an overall finding of this study was that coping and motivation measures together showed much greater power to explain school achievement than previous non-cognitive measures. Peck (1977) has also used peer and teacher ratings, based on observations, to evaluate coping behavior. Teacher ratings easily factored into academic and social coping factors and were highly predictive of educational achievement.

Some rough parallels of this model of the coping process already exist in the adaptive behavior literature. Initiative, planning, and persistence are three adaptive behaviors in the Part I, Section VIII "Self-Directions" of the Adaptive Behavior Scale (Nihira and Shellhaas, 1970). Leland (1978) indicates that the elements of coping behavior are: (1) what the individual is able to do, (2) what he/she is motivated to do, (3) age expectations, and (4) general societies' expectations. Peck's model of coping includes the first two.

In reality, persons with mental deficiencies are expected to have problems enacting this process of coping. Confronting problems is no small task because it demands awareness of a problem situation. Lewis and Mercer (1978), Leland (1978), and others consistently point out the problem of the mentally retarded not being aware that demands on them have changed as they move from one situation to another. Even if the person becomes aware of a problem situation, he/she must still decide whether to focus their attention and energy on that problem. The next part of the process, engaging the problem, is the area of deficit most attributed to the mentally retarded. Engaging the problem entails seeking possible solutions and choosing one to enact (Fullan & Loubser, 1972). Limits on mental functioning are a definite handicap in this part of the process, but if problem situations are broken down into least-complex forms, this part of the process of coping can be accomplished. The third component of the process, persistence at trying out solutions, is seldom mentioned in the mental retardation literature. Finally, achieving solution probably varies with the level of mental ability, motivation, and the complexity of problem usually chosen. In all, knowledge of this coping process may be more helpful to the educable than trainable mentally retarded.

Given this reality, a process-of-coping model still has usefulness in the planning of intervention programming. It conceptualizes a process of how-to-cope which can be taught and then applied to many situations. This process also indicates what behavior to observe, as an assessment of what components of the coping process a person is not doing. The model also indicates a sequence of behaviors to expect when observing.

Given this model of coping, what could be done to facilitate adaptation, the reversible part of mental retardation? More specifically, the question is, "How do you translate a coping process into something to teach?" Perhaps a mentally retarded person's habitual coping style can be classified and her/his use of the coping process can be observed. The parts of the coping process they emphasize probably, in a large part, determines coping style. Once that person's version of the coping process is known, then an intervention/training program can be constructed and implemented with that person. The purpose of the training would be to help them apply the coping process in each situation they encounter. Obviously the people, and their training, will differ by intelligence level, age, and sex. With the mentally retarded, the problem of generalizability across situations is the bottom-line criterion for a training procedure. Ideally, they need a model of the coping process that can be applied to each situation as it is encountered.

Training coping behavior in mentally retarded and normal people is not without precedent. In fact, training studies have been done on skills pertaining to independent functioning, and personal and social responsibility.

The Texas State Learning Resource Center (1977) has formulated a guide to training materials that correspond to the "independent functioning" behaviors on the Adaptive Behavior Scales, Part I. For example, "tooth brushing" has about eight different sources of training materials. A similar guide was assembled for the adaptive behavior listed on the Camelot Behavioral Checklist (Texas State Learning Resource Center, 1977).

Several projects have attempted to teach problem-solving (which corresponds to "personal responsibility" adaptive behaviors) to mentally retarded and normal children. Pinkerton (1978) taught problem solving to a group of 28 mildly or moderately mentally retarded people, 19-35 years of age. She used videotaped problem situations with peers, parents, and institution employees. The participants were asked to generate solutions. Then the training consisted of group discussion, role models, and reinforcement for problem-solving efforts. Using the Adaptive Behavior Scale as a criterion, the treatment groups made significant gains in the Vocational Activity area, in comparison to the control group. Another significant training study was done with normal children by Spivack and Shure (1974). They have outlined excellent teaching plans for teaching a cognitive approach to personal and social problem solving. They diagnose the errors in thinking and use games as teaching techniques.

The most comprehensive attempt to alter and teach coping behaviors was done by Spaulding (1970). In a large study with a school system, he classified children by six coping styles and constructed teaching formats to enhance the favorable aspects of that coping style. The

teaching formats were for entire classrooms, and across the school year. Social learning and behavior modification techniques were used in the construction of these training programs. His measure of coping style, A Coping Analysis Schedule for Educational Settings, and his treatment schedules could easily be applied in training of mentally retarded people.

Both Spivack and Shure's (1974) and Spaulding's (1970) methods were applied to teaching "social responsibility", as well as academic skills. Wowkanek (1977) helped children learn social skills by fantasizing their possible coping strategies. Bates (1978) tried an interpersonal skills training program on institutionalized, mildly or moderately retarded people. He found the training effective for the specific situations which were role-played, but not effective in a trip to a store outside the institution. However, Stacy, Doleys, and Malcolm (1979) reported positive effects of a social-skills training program upon the behavior of eight previously institutionalized, mentally retarded adults. Using audio and video-taping during role-play, self-assertion skills were taught, and some generalization to unfamiliar situations was obtained.

Looking at these training programs, obviously the initial part of the coping process, i.e. confronting the problem, is not being taught. The problem situations are artificially provided. Therefore the participants do not have an orientation model to use to help them start the coping process in each new situation. Defining and clarifying a problem situation is necessary in order for a person to initiate efforts to handle the problem. Failure to do this spontaneously is part of the

"generalizability" problem with most training studies. Perhaps "confrontation training" might involve drills on "Does a problem exist here? How?" Most of these training programs concentrated on the "engaging" part of the coping process, however only one (Spivack and Shure, 1974) systematically taught the components of generating possible solutions and selecting one. Encouraging persistence was probably a part of each of these training programs, but it was not included as an objective in any. On the whole, however, it is encouraging to find training studies on parts of the coping process that indicate possible teaching techniques to use.

In summary, this paper has provided a conceptual framework for the analysis of adaptive behaviors. The coping process is the process of achieving adaptive behaviors. A model of the coping process has been provided, explained, and applied to the intervention/programming purpose of adaptive behavior theory. The limitations on this application of the coping process were explored. Finally, examples of training studies pertaining to the coping process were provided to demonstrate a completely conceptualized and operationalized training program could be put together.

Coulter and Morrow (1978) pointed out that attempts at intervention/programming based on adaptive behaviors assumes that the behaviors that can be measured can, in fact, be trained. Their suspicion of the intervention/programming endeavor is reflected in their question, "Is it possible that too much has been assumed regarding the capability of the training technology to inculcate skills?" (p. 222) Actually, so far few intervention programs have been based on the adaptive behavior

concepts and measures, their suspicion seems premature. In this paper, the coping process model is offered as a guide to the construction of intervention and planning programs for the mentally handicapped.

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